Placement and Residential Licensing Unit
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
P: 501.682.8590 F: 501.683.6060 TDD: 501.682.1550

Notice of Serious Incident

Case Number: 023158

Date of Incident: 8/11/2024

Date Received: 8/12/2024

Facility Name: Perimeter of the Ozarks

Facility Number: 237

Incident Type: Dual

Report Description: ? Serious injury requiring outside medical attention ? Resident?s attempted suicide X Allegation of abuse/neglect related to a restraint ? Resident?s death ? AWOL/Elopement ? Allegation of sexual/physical abuse ? Sexual Misconduct ? Other Patient/Resident Name/DOB: [redacted], [redacted] and [redacted] Date/Time of incident: 08/11/2024 at 17:20 Patient Insurance: [redacted] Agency Name of Perimeter Staff Making Notification Date Time Name of Person Notified DHS [redacted] Director of Risk Management 08/12/24 18:00 [redacted] Disability Rights Center, Inc. [redacted] Director of Risk Management 08/12/24 18:00 incidentreporting@disabilityrightsar.org Perimeter [redacted] Director of Risk Management 08/12/24 18:00 [redacted] Chris Perry, [redacted] Guardian/Caseworker [redacted] Director of Risk Management 08/12/24 16:30 14:25 14:36 [redacted] Director of Risk Management 08/12/24 Signature and title of staff completing this form Date: Name of Facility: Perimeter Behavioral of the Ozarks? Phone Number: 479-957-9857 ext. 108 Street Address, City, State, Zip: 2466 S. 48th Street Suite B. Springdale, AR 72762?? Please describe the incident: On 8/11/24, Residents [redacted] and [redacted] were involved in an incident in which they engaged in property damage. Staff stood aside until residents began throwing items at and breaking a light fixture, which increased the risk of danger to staff and youth. This led to staff intervention and a physical confrontation as residents started assaulting staff. Each resident was restrained. During the debrief, [redacted] Nurse, raised concerns regarding the level of force deployed. On 8/12/24, [redacted] Director of Risk Management, and [redacted] Director of Nursing, reviewed camera footage of the incident and noted Mental Health Technicians [redacted] and [redacted] actions

did not align with the company?s Restraint and Seclusion Policy. Specifically, it looked as if [redacted] twice kicked a resident that was being restrained on the ground, [redacted] was seen swinging her fist back at a resident to try to get her to release her from a hair pull and later hitting a resident to try to get them to release another staff member, and [redacted] is viewed leaning over a resident on the ground with his forearm pressed against her neck. Residents were medically assessed, and [redacted] presented with a bump on the back of her head and a split lip. Actions Taken: ? [redacted] (Investigation ongoing) ? Staff suspensions. ? Medical assessments for [redacted]

Interim Action Narrative:

Maltreatment Narrative:

Licensing Narrative: 8/13/2024- Program Manager emailed the facility to determine the residents guardianship status and confirm the ICA for the three staff involved. Program Coordinator requested permission to contact the facility from [redacted] Background check status was requested from [redacted] for all three staff named in the complaint. [redacted] confirmed all three had their background checks completed and approved. [redacted] gave permssion to contact the facility. 8/14/2024 - Licensing specialist reviewed the complaint and will conduct a visit with Program Coordinator [redacted] to review video footage and initiate the complaint. 8/15/2024 - A visit was conducted with [redacted] to review camera footage with time stamp 8/11/2024 17:00 - 17:24 and 17:24 - 17:47. Licensing sat in on interviews with [redacted] and residents named in this complaint. Program Coordinator took a picture of the items the residents attempted to use as weapons toward staff. Licensing observed Unit Green and observed the light cover missing that the residents broke. Facility stated that cover plate has been ordered. The light bulb appeared to be covered with some type of covering. No headphones were observed in the dayroom area on the shelf. Program Coordinator also sat in with [redacted] who spoke with resident's [redacted] case manager and therapist. Program Coordinator provided therapist with contact information so that she could email a statement. 8/16/2024, Program Coordinator received a statement from resident [redacted] therapist and it has been uploaded. Program Manager inquired about the date that the incident was [redacted] Facility reported 2 [redacted] on 8/12/2024 and provided documentation.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
P: 501.508.8910 F: 501.683.6060 TDD: 501.682.1550

521 Visit Compliance Report

Licensee: Perimeter of the Ozarks

Facility Number: 237

Licensee Address: 2466 SOUTH 48TH STREET
SPRINGDALE AR 72766

Licensing Specialist: Kendra Rice

Person In Charge: Charriot Sales

Record Visit Date: 8/15/2024

Home Visit Date: 8/15/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

Time of Visit: 10:00 am to 12:45 pm

Census: 27

Licensing received a complaint on 8/12/2024 for ELS Case #023158.

Program Coordinator met [redacted] at the facility. Program Coordinator, [redacted] and Director Risk Management [redacted] discussed the complaint.

[redacted] reported that all three (3) staff members involved have/will be terminated. The facility is waiting for two (2) staff members to complete paperwork. [redacted] also reported that she [redacted]

Program Coordinator sat in on the interview with [redacted] and resident. When [redacted] asked resident if she knew why she wanted to talk with her, resident stated "yes." Resident was able to answer all interview questions from [redacted]

When asked if she had any bruises, resident stated she had bruises on her right arm, bumps on the back of her head, and scratches on her chest (breast area). Resident pulled her right arm out of her sweatshirt and showed what appeared to be a faded bruise and another marking on the inside of her arm between her shoulder and elbow. [redacted] took a picture of the resident's arm and felt the back of her head.

Licensing is not prepared to leave a finding at this time and the assigned Licensing Specialist will continue to monitor this complaint.

Provider Comments:

CCL Staff Signature :

Date: 8/16/2024

Provider Signature :

Date: 8/16/2024

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521 Visit Compliance Report

Licensee: Perimeter of the Ozarks

Facility Number: 237

Licensee Address: 2466 SOUTH 48TH STREET
SPRINGDALE AR 72766

Licensing Specialist: Jarred Parnell

Person In Charge:

Record Visit Date: 8/15/2024

Home Visit Date: 8/15/2024

Purpose of Visit: Complaint Visit

Regulations Out of Compliance:

Regulation Number: 100.109.1.g

Regulation Description: Unprofessional conduct in the practice of child welfare activities shall include, but not limited to the following:

Finding Description: Staff members engaged in behavior that could be viewed as dangerous or physically harmful to a child.

Action Due Date:

Action Due Description:

Comply Date:

Sub-Regulation Level 1 Description: Engaging in behavior that could be viewed as sexual, dangerous, exploitative, or physically harmful to children.

Action Due Description:

Regulation Number: 900.905.4.g

Regulation Description: The following actions shall not be used, including as discipline:

Finding Description: Staff members used physical injury or the threat of injury in the course of managing the behavior of residents.

Action Due Date:

Action Due Description:

Comply Date:

Sub-Regulation Level 1 Description: Physical injury or threat of bodily harm;

Action Due Description:

Regulation Number: 900.905.9

Regulation Description: Physical restraints shall be performed using minimal force and time necessary. Physical restraint means the application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body. Briefly holding a child without undue force in order to calm or comfort, or holding a hand to safely escort a child from one area to another, is not considered a physical restraint.

Finding Description: Staff failed to use the minimal force necessary during the course of a restraint hold on a resident.

Action Due Date:

Action Due Description:

Comply Date:

Action Due Description:

Regulation Number: 100.110.9.c

Regulation Description: Any owner, operator, employee, foster parent, or volunteer in a child welfare agency shall immediately notify the Child Abuse Hotline if they have reasonable cause to suspect that a child has

Finding Description: The facility failed to report the incident immediately to the Child Abuse Hotline. The incident occurred on 8/13/2024, but the hotline was not notified until 8/14/2024.

Action Due Date: 2024-08-23

Action Due Description: All staff at the facility need to be retrained on mandated reporting and their responsibilities as a mandated reporter per Arkansas law.

Comply Date:

Sub-Regulation Level 1 Description: If they observe a child being subjected to conditions or circumstances that would reasonably result in child maltreatment.

Action Due Description: All staff at the facility need to be retrained on mandated reporting and their responsibilities as a mandated reporter per Arkansas law.

Regulations Needing Technical Assistance:

Regulation Not Applicable:

Regulations Not Correctable:

Narrative:

August 15, 2024 – A visit was conducted at the facility to review video footage for complaint 023158. Video footage timestamp - 8/11/2024 – 17:00 – 17:47 was reviewed.

Video footage starts and seven staff members can be seen in the left corner of the day room on the green unit. There are three residents in the top right corner near the window and closet the three residents are [redacted] and [redacted] Staff are trying to verbally process and de-escalate with the residents and residents can be seen speaking with the staff. One of the residents is seen holding a broken piece of headphone band to use as a weapon. The residents can be seen throwing books at the lights in the ceiling and staff begin to close in around the residents. At 20:20 one of the staff can be seen reaching in for the headphone band and takes it. The staff grabs the object and runs from the group while the other staff step into issue restraints. There is a physical struggle for a moment and staff [redacted] issues a hold and puts a resident on the ground. While on the ground [redacted] can be seen pushing his arm into the back of the neck of the resident. Staff person [redacted] can be seen in the back of the struggle come out and began moving forward. While moving [redacted] kicks the restrained resident in the head. The staff member [redacted] can be seen trying to strike a resident with a closed fist behind her and then moves forward to strike another resident with a closed fist. The other staff can be seen trying to initiate restraint holds and get control of the residents. The incident lasts approximately 1 minute. After the altercation, the residents can be seen in restraint holds on the ground as the staff persons are trying to verbally de-escalate and begin processing until everyone has calmed down.

A walkthrough was conducted of the facility green unit, to inspect a damaged light cover from the residents throwing books at it to break it.

Licensing specialist observed two resident interviews between [redacted] and [redacted] and DHS [redacted]

The facility has terminated [redacted], [redacted] and [redacted] in response to the incident. The residents have been placed on assault precautions and increased supervision. There was a light cover damaged from the residents throwing books at it. The light bulbs have been removed from the light fixture and the cover has been removed. The light will be repaired as soon as a new cover is received.

Licensing complaint is founded.

Provider Comments:

CCL Staff Signature : [signature] Date: 8/16/2024

Provider Signature : [signature] Date: 8/16/2024